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THE
Hampden Hippocrat
NOVEMBER—DECEMBER 1993

In This Issue

District Meeting 2
President's Message 4
Rabies, Coons, Dogs and Viruses 6
Letter From The Agawam Animal Hospital 10
The Religion of Medicine 12
Hampden Committee Activities 17
In Memoriam 18
New Members Welcome 19
Bill And Hilary Meet Santa 21
Christmas 24

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HAMPDEN DISTRICT MEDICAL SOCIETY 1993-1994 SEASON

DISTRICT MEETING

PLACE: **SHERATON SPRINGFIELD**
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BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., SPOUSES ARE WELCOME!

SPEAKER: ROBERT E. McAFEE, M.D.
President-Elect, American Medical Association

SUBJECT: AMA Reports On The Issues

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From the Editors

This issue marks the end of another publishing year. To Americans regardless of tradition or national origin, this is a season for reflection and renewing our ties to family and friends.

Your editors wish you a joyful holiday season and we hope the new year brings us all peace, growth, and happiness.■

Brigid Glackin, M.D.
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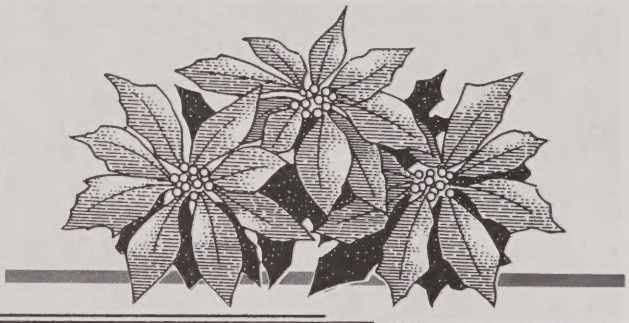

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Practice Parameters

As our national health care expenditures have escalated over the past three or four decades, those parties paying the bills (third party payors or, increasingly, Government) have been analyzing

Francis D. Horrigan, M.D., President

their costs and benefits vis a vis the services received. The analyses have, in some instances, recognized widely divergent strategies of care and resource utilization resulting in significant variation in cost without corresponding difference in benefit. Over the decades a variety of maneuvers, often adversarial, have been implemented to insure cost efficiency (without compromising quality)—the parentheses indicate a priority decision designed to make the cost saving measures palatable. The results have included a series of programs and acronyms (UR, QA, peer review, pre- post- and ongoing admission review) that have failed to stabilize our health care system and have only interposed layers of acrimonious micromanagement between physician and patient.

Such systems create conflict, in part, because they impose paradigms on a process— physician caring for patient— that are totally foreign to that relationship. The patient looks to the physician to apply the maximal skill to the clinical problem. The physician does not gain that skill by actuarial analysis but by experience, consultation, journals, courses, meetings, etc. For a physician caring for a sick patient a DRG statement is virtually meaningless.

Practice parameters potentially can be a useful tool in bridging the gap between clinical freedom and sound health economics by giving the physician the benefit of medical consensus and by defining for society what to expect during

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a particular illness. In order to be relevant and acceptable a practice parameter must originate from a credible source using relevant research and clinical expertise based on current information and must state comprehensive specific information to be widely disseminated. To accomplish these goals the AMA has developed and coordinated two bodies— the Practice Parameters Partnership which includes also the AHA, JCAHO and AHCPR to influence utilization of developed parameters.

Benefits of practice parameters would include (1) provision of features of care agreed upon by physicians of recognized scientific and clinical skill to be useful in certain clinical situations (2) provision of an acceptable basis from which improvements in patient management can be developed (3) production of a measure of uniformity of management across the country (4) potential value in production of savings in malpractice insurance and defense.

There are potential downsides to practice parameters that need to be addressed and monitored: (1) misuse of parameters to limit care for purely economic motives (2) misuse of parameters to stifle creative aspects of care by directing research solely on economic motives or by stifling application of newer technologies creating a medical "Dark Ages" (3) misuse of parameters by granting them a character of immutability to be altered only by herculean effort.

For maximum benefit from the labor spent to develop useful parameters certain cautions must be heeded. Grass roots acceptance by practicing physicians actually delivering care is essential. Parameters must be relevant, applicable in the present, and encouraging of medical advance. Development, dissemination and discussion among specialty societies, local medical societies and other physician groups is the best mechanism for this to occur. To be maximally useful, practice parameters should be clearly identified as such and widely disseminated through broadly accessible channels to avoid confusion with position papers of internal interest to various groups that may be published in similar media i.e. particular journals. Also there must be a clearly identified mechanism to accommodate those rare but thrilling quantum leaps that can occur— for example thrombolytic therapy for MI that catapulted from research curiosity to almost universal application in just a couple of years. Practice parameters must always recognize that a patient is not a parameter. Ultimately the physician on the scene has the responsibility and freedom to deliver the proper care.

We should be extremely wary of practice parameter "look alikes, developed by those outside the accepted framework. Such parameters may be brought forward by special interest groups with a political or economic goal other than quality patient care. Such occurrences should be resisted at both the individual and organizational level. Examples might include down racheting of services "not of proven benefit"—definitions vital here—or expanding into areas other than scientific care to judge physician attributes using methodologies irrelevent to good medicine (physician report cards).

Properly developed and disseminated practice parameters can be reassuring to patients and physicians alike by demonstrating that the desired level of care is already here and forming not an endpoint, but a beginning for ongoing improvements in the quality of care accessible to all our patients. ■

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Rabies: Coons, Dogs, And Viruses

The following article was written by Robert E. Hoffman, M.D., a specialist in Infectious Disease. It is crucial that these issues be recognized by practicing physicians.

The ancients knew about rabies. They called Sirius the 'dog star' because it lit the late summer sky, and it was in late summer that they believed dogs were prone to spells of madness. A thirteenth century Persian medical manuscript gives this interesting, but not entirely accurate, description of the course of the disease we now call rabies;

> 'And they sweat. Some of them flee from the light and some of them take pleasure in it. Some of them bark like dogs. At times, one who approaches them may become similarly afflicted. People have reported that they have seen one or two persons who were bitten and escaped.'

In North America, the first reported outbreak of rabies among domestic dogs occurred in the early 1700's, and by the end of the century rabies was widespread among domestic animals. Over the next century the infectious nature of the affliction became known to physicians and veterinarians around the world. The modern era of rabies treatment began in 1885 with the development, by Louis Pasteur, of a live virus vaccine. Pasteur's vaccine was similar to modern anti-rabies treatment in that it required the injection of repeated doses of the virus to induce a protective antibody response.

The crude original rabies vaccine caused frequent, occasionally fatal reactions, a problem only partially overcome for almost a century. Fortunately, since 1980, a very safe and highly effective vaccine has been available to American physicians. The vaccine is very expensive, but when used appropriately, it allows us to offer hope to victims of contact with rabid animals. Even with effective post exposure treatment, the emotional toll on individuals exposed to rabies is usually enormous. Thus, it remains wise for physicians to counsel patients about the need to avoid situations which pose a high risk of rabies exposure.

In the last ten years, the total number of rabid animals is increasing.

Few of us have ever seen a case of human rabies. For many years the disease was more common in medical history books than on the wards of our hospitals—the result of the progress of veterinary medicine and innovations in vaccine development. An effective, non toxic vaccine designed for dogs became available in the United States in the 1940's. Effective control of stray dogs, and a very effective post-exposure vaccine for humans, led to the virtual disappearance of human rabies in this country in the 1950's. In other parts of the world, however, rabies continues to be a public health problem. Tens of thousands of human cases occur each year outside the United States. The majority of cases of human rabies seen in this country for over a generation were acquired elsewhere.

Despite our success in preventing rabies in domestic animals and humans, our southern and border states continue to have rabies documented in wild terrestrial animals. Rabid carnivores easily cross and recross the border with Mexico. Rabies persisted in bat populations throughout the United States during the era in which human cases almost disappeared.

In the last ten years, the total number of rabid animals in this country has been increasing. Of the approximately 7,000 cases of animal rabies seen last year the vast majority occured in wild animals—predominantly skunks, bats, and raccoons. The rapid expansion of an epizooic of raccoon rabies is now threatening

our domestic animals. Moving northward since its appearance in Florida forty years ago, the raccoon epizooic reached the middle Atlantic states 25 years ago, and spread to our neighboring states during the last few years. Last year, a rabid raccoon was reported outside Boston, and we have had reports of rabies in wildlife in Springfield's suburbs in recent months. Since raccoons are more plentiful in urban and inner suburban regions than they are in the forests, most of our patients risk exposure to the virus.

The appearance of a new threat to the health of the public brings to physicians additional responsibilities. We can be resources for disseminating information about the disease to our respective communities, and must be prepared to begin treatment of patients in high risk situations. Just as importantly, by becoming knowledgeable about rabies, we can help allay fear in our patients in situations which do not require intensive anti-rabies treatment.

In the last ten years there have been only six cases of human rabies in the United States. Of these, five were related to exposure to bats and only one followed a domestic animal bite. Every use of post-exposure rabies vaccine treatment has been successful. Clearly, when treatment protocols are carried out correctly, human rabies should not occur. In light of the availability of such uniformly effective treatment strategies, physicians have an obligation to know and understand the principles of post exposure rabies prophylaxis. With the northern extension of the epizooic of rabies in raccoons, virtually every animal bite and scratch must now be evaluated for rabies. Since few of us have treated rabies—or even seen a case of human rabies, a review of the signs and symptoms of the disease, as well as instruction in post exposure prophylaxis, is necessary.

Rabies is caused by a *rhabdovirus* and begins its multiplication in the muscle near the site of inoculation. Nearby nerve endings are infected next, and nerve invasion often is accompanied by pain or tingling in the involved dermatome. With an understanding of the initial pathophysiology of the disease, it is clear why part of the acute treatment of a suspected rabid bite includes infiltration of the area around the wound with preformed antibodies in the form of rabies immune globulin. Half of the suggested dose of rabies immune globulin is routinely given in this fashion. The remainder of the dose should be injected into a distant muscle site. This use of passive immunization

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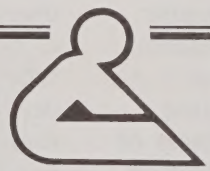

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Rabies

Continued from previous page

with anti-rabies antibodies is effective if given within seven days of the original bite. Of course, thorough cleansing of the wound, as well as appropriate anti-tetanus treatments, is as necessary for the bite of a rabid animal as it is for any other wound.

In addition to the use of rabies immune globulin, treatment of an exposure to rabies should include the use of rabies vaccine. The current anti-rabies vaccine is made in a human cell line and is a killed virus. The rate of adverse reactions to this vaccine is extremely low, especially for the first course of therapy. Approximately 6% of individuals who receive the vaccine as preexposure prophylaxis (veterinary care workers, animal handlers, forestry workers or cave explorers) and receive frequent booster doses, experience immunologic side effects. For individuals receiving their initial course of the vaccine, reactions rarely interfere with completion of the five injection course of therapy. However if a significant adverse reaction to the standard human diploid rabies vaccine occurs, an alternative vaccine can be obtained.

Injections are given intramuscularly, in the deltoid region. The use of concurrent passive and active immunization presents no problem, provided dosing guidelines are adhered to strictly. The use of excessive rabies immune globulin may interfere with the effectiveness of the vaccine by inhibiting the production of endogenous antibodies. For a similar reason, rabies immune globulin and rabies vaccine should not be mixed and given in a single injection, and the two injections should be given at separate sites.

Human diploid rabies vaccine has been the standard post exposure rabies treatment for the past dozen years. Safe and highly efficacious, the current vaccine requires only five inoculations. The first four doses should be given within 14 days, with the last, or booster dose coming any time after 28 days. The cost of rabies vaccination is very high—as much as $1,000 dollars for the full course. Thus, each time the vaccine is given a decision must be made that the risk of rabies infection justifies the cost of the vaccine.

Most of us had been comforted in the past by the rarity of rabies in Massachusetts. With neither wild nor domestic animal rabies in the entire state, our professional competence in recognizing signs and symptoms of the disease had rarely been challenged. The appearance of rabies in local wild animals raises the risk of infection of domestic animals, which increases the likelihood that any animal bite is rabid. A history of rabies vaccination in any domestic animal suspected of biting a patient is very reassuring. Less important is the issue of whether an animal attack has been "provoked" by the patient. Since terrestrial animals, including pets, are generally territorial, many "unprovoked" attacks are the result of the animal believing its territory has been invaded. Only unusually aggressive or bizarre behavior by an animal may represent a truly unprovoked attack. Among wild creatures, fear or disorientation can easily be confused with aggression. Thus, although the treating physician must attempt to obtain a very detailed history of the circumstances of an attack, the most useful information will result from locating the animal involved and evaluating its likelihood of being rabid.

Rabies may be contacted by the aerosol route, a pathogenesis rare but well documented in spelunkers and laboratory personnel. Also quite rare is the transmission of rabies by the passive entry of salivary secretions into open wounds. Despite its description in the records of physicians in antiquity, human to human transmission of rabies has never been documented to occur. In those parts of the modern world where tens of thousands of cases of rabies are documented annually, no cases have been found secondary to human bites. On the other hand, rabies has been documented in several recipients of corneal transplants from rabies victims.

Entry of the rabies virus into the central nervous system is a fatal event. The infection of medullary and pontine centers, the cranial nerve nuclei adjacent to the fourth ventricle, and finally cortical invasion, coincides with the clinical appearance of abnormalities in the muscles controlled by nuclei in those areas. Difficulty swallowing secretions due to spasms in throat muscles and poor coordination of swallowing muscles occasionally gives rabid animals the appearance of foaming at the mouth. However rabid animals are likely to be unusually passive (due to rabies encephalopathy) as often as aggressive and foaming at the mouth. In nature, rabid animals die from spasm of the respiratory muscles, attacks from other animals, or encephalitis. Humans die from rabies with cardiovascular collapse, secondary pneumonia, and encephalopathy.

Despite the effectiveness of post exposure rabies prophylaxis, the cost, anxiety, and effort involved makes it mandatory that we increase our efforts to minimize the risk of human exposure to the rabies virus. The Massachusetts Department of Public Health estimates that more than 80% of animal bites of humans are preventable. More than two thirds of bites are associated with people petting or feeding wildlife or domestic animals they don't know. Virtually any carnivore may contact and transmit rabies, although raccoons, skunks, bats, foxes and wolves cause almost all known cases caused by wildlife in this country. Despite the rarity of rabies in domestic animals, caution must be exercised when approaching domestic animals with whom we are not familiar. It is comforting to know that rodents and legomorphs (rabbits and hares) very rarely transmit rabies. Birds, reptiles, and fish cannot contact the disease.

A list of recommendations made by the Department of Public Health is included at the end of this article. Of the recommendations, the most important may be the suggestion to teach children to avoid wildlife and strays. The "Love Your Own, Leave Others Alone" logo and curriculum was mailed to every school in Massachusetts. Also extremely important is the advice to vaccinate all cats and dogs against rabies.

A second addendum to this article includes instructions for the management of animal bites. Further information can be obtained from the Massachusetts Department of Public Health at (617) 522-3700, ext. 420, or after hours and on weekends, (617) 522-3700. Additionally, our office will be available for emergency consultation and advice (739-5676).

The problem of rabies in our wildlife is not likely to go away in the immediate future. As long as rabies is present in wild animals, it will pose a threat to our pets, and thus to ourselves. Our ability to take comfort in the knowledge that rabies was someone else's problem disappeared when the raccoon rabies epizooic reached Massachusetts. It is now the obligation of every physician to understand the behaviors associated with contacting the disease, its emergency treatment, and where to get expert help for both managing the disease and reassuring our patients. As physicians, we can do very little to limit the epizooic of rabies in wildlife—and so we must accept the challenge posed by the disease. Our goal should be the prevention of human rabies using both education and the excellent treatments available. We must use our professional judgement to recognize those situations requiring early, aggressive intervention. A human death from the bite of a rabid animal has not occurred in Massachusetts for a decade. The continuation of that perfect record is our challenge. ■

ATTACHMENT 1

F. PUBLIC EDUCATION

Advice given to the public should include:

- Do not touch or pick up wild or stray animals of any kind.
- Avoid sick or strange-acting animals.
- Vaccinate all cats and dogs against rabies.
- Teach children to avoid wildlife and strays.
- Fasten trash can lids tightly. Garbage attracts raccoons.
- Cap chimneys and seal openings into houses, etc., to prevent raccoons from entering or building dens.
- If you are bitten or scratched by any animal, you should promptly wash the wounds with soapy water and see a doctor immediately.
- If your pet has been bitten or scratched by any animal, wear gloves, wash the wound with warm soapy water for at least ten minutes, and contact your veterinarian immediately.
- Teach children to avoid wildlife and strays via the "Love Your Own, Leave Others Alone" logo.

Continued on next page

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Rabies

Continued from previous page

ATTACHMENT 2

RABIES POST EXPOSURE SCHEDULE, UNITED STATES, 1991

Vaccination Status	Treatment	Regimen[1]
Not previously vaccinated	Local wound cleansing	All post-exposure treatment should begin with immediate thorough cleansing of all wounds with soap and water.
	Human Rabies Immune Globulin (HRIG)	20 IU/kg body weight. If anatomically feasible, up to one-half the dose should be infiltrated around the wound(s) and the rest should be administered IM in the gluteal area. HRIG should not be administered in the same syringe or into the same anatomical site as vaccine. Because HRIG may partially suppress active production of antibody no more than the recommended dose should be given.
	Vaccine	Human Diploid Cell Vaccine (HDCV) or Rabies Vaccine Adsorbed (RVA), 1.0 ml, IM (deltoid area[2]), one each on days 0,3,7,14 and 28.
Previously vaccinated	Local wound cleansing	All post-exposure treatment should begin with immediate thorough cleansing of all wounds with soap and water.
	HRIG	HRIG should not be administered.
	Vaccine	HDCV or RVA 1.0 ml, IM (deltoid area[2]), one each on days 0 and 3.

1. These regimens are applicable for all age groups, including children.
2. The deltoid area is the only acceptable site of vaccination for adults and older children. For younger children, the outer aspect of the thigh may be used. Vaccine should never be administered in the gluteal area.
3. Any person with a history of pre-exposure vaccination with HDCV or RVA; prior postexposure prophylaxis with HDCV or RVA; or previous vaccination with any other type of rabies vaccine and a documented history of antibody response to the prior vaccination.

Note: It is extremely important the vaccine be administered in the deltoid in adults and in the anterolateral thigh in infants. Vaccine failure results when it is *not* given at the correct site.

(Adapted from: CDC, MMWR 1991; No. RR-3.)

Letter From The Agawam Animal Hospital

As a veterinarian located in Western Massachusetts, I deal with the issue of rabies on a daily basis. The veterinary community in this state has accepted the fact that it will be the first line of defense in the progression of the current epidemic. While attempting to organize every community within the state, several agencies on the local level were made aware of the epidemic and how they might be affected. The medical community was also approached and it became increasingly apparent that physicians are unprepared for the appearance of an epidemic of rabies.

Rabies is a disease which can infect any mammal. Physicians in several areas of specialty can be exposed to aspects of this disease through their patients. I encourage the physicians in this state and their respective organizations to take a more proactive stance toward the understanding of this disease and its potential effects on the public at large. To achieve maximum effectiveness in preventing loss of human and animal life, we all need to work together toward a common goal.

Sincerely,
John E. Guntly, DVM

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American Medical Association

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For Your Benefit

Clinton's plan has AMA elements, yet medicine cannot endorse it

The AMA neither endorsed nor opposed President Clinton's entire health system reform plan, saying it will continue to maintain dialogue with the administration, congressional leaders, and Republican and Democrat sponsors for other proposals to ensure nonpartisan discussions result in final legislation "that puts our patients first."

"We disagree with certain of the president's strategies to achieve commonly shared goals, and we will neither endorse nor oppose the president's preliminary plan in its entirety," the AMA said.

Although it welcomed Clinton's affirmation of many AMA reform principles, the Association warned that the plan's reliance on price controls and overregulation, and its new layers of governmental bureaucracy will limit patient and physician choices, lessen the quality of medical services and undermine the mutual trust between patient and physician.

"While the president proposes rigid spending limits that would also limit resources for patient care, the plan does not consider adequately other major cost-saving areas like liability and antitrust reform," the AMA said.

Financing and implementation issues continue to cause concern as Clinton did not clearly address how he plans to finance reform and that his timetable to enact the plan may be "too aggressive."

The Association cautioned that "heavy reliance on cuts in Medicare and Medicaid for financing is an unrealistic, short-term solution that could threaten medical services for the poor and elderly in the future."

AMA stated Clinton may be creating expectations that cannot be met.

"If anticipated savings fail to materialize from his reform plan, deep reductions in medical services may follow, as many leading economists warn, thus defeating reform's primary purpose," the AMA said.

Actual legislative specifications of Clinton's plan are expected in October. Clinton's speech "is just the beginning of the most important domestic debate of our lifetime," the AMA said.

Dialogue between the administration and AMA will continue during the next stages of the reform process.

The Association also is meeting with congressional leaders and sponsors of Republican and Democratic system reform plans.

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

The Religion of Medicine

The following reflects the thought of Dr. Arthur Krol, a surgeon at the University of San Francisco during the '60's. It seems appropriate to reflect on these issues during this season.

Since the classical age of Greece and probably even before, those who cared for the sick recognized that their work had elements of a religion. The term "religion" comes either from the latin "res legio" (pertaining to law) or" religio" (to relink). Even in our modern secular society, those who practice medicine, regardless of their formal religious affiliations or beliefs continue to recognize in each other something which sets the physician apart from the rest of society; certain fundamental obligations upon the physician; and a certain kinship between physicians that transcends personal friendships, fame or obscurity, age or youth, gender or race, academia or the front lines of practice. This is reinforced by society, both positively (the regard we receive from patients and society at large) and negatively (that feeling of persecution from government, insurance companies, the legal profession, etc.)

The practice of medicine, first and foremost, has the potential to change the physician for the better.

While not presuming to review the whole subject, this essay is a reflection upon some of the personal qualities that exist as ideals for the physician.

A. The Attitude of Unconditional Positive Regard.

One of the most important qualities of a good physician is the ability to regard patients, colleagues, co-workers, and in fact, everyone he/she comes into contact with, in a positive way. Obviously, this regard is modified by experience; soon one learns that certain individuals must be regarded with a bit of suspicion, or in extreme cases, even avoided. But the point is that on the initial encounter, there is willingness to accept the patient as he/she is, and to believe the story heard.

The opposite of this quality is suspicion, which greatly interferes with the physician's ability to be of service to his/her patients, or work effectively with others. It is crucial to begin each encounter "innocently" so as to avoid the habit of reacting to attitude, dress, speech or appearance with premature judgement.

B. Equanimity

William Osler delivered an entire graduation speech on what he considered the fundamental virtue of the physician. Equanimity he defined by description, using words such as "phlegmatic", "cerebral", "methodical", "unemotional"; had he lived today, he might have added "cool". Osler felt that this quality needed to be cultivated over one's lifetime; it was not inborn, and never completely mastered. There were several reasons for active pursuit of this virtue. The equanimitous physician calmed patients and by his/her presence, aiding the healing process; the equanimitous physician led the health care team more effectively, since he/she seemed to know what he/she was about. The possession of the virtue allowed for access to the reasoning processes, which are often hidden when emotion is in the driver's seat. Finally, the quality of equanimity allowed the physician to be a human being in the face of inadequacy, suffering, and death; it was possible to learn to guard the center of one's being from the everyday events which confront the physician.

C. Respect for the Truth

The good physician cultivates honesty in his/her professional life. This is not only honesty to patients and co-workers, but to oneself. This

is an honesty which is perhaps deeper and more serious than the "average" honesty one finds in society at large.

The physician in training is often insecure in his/her body of knowledge and ability to use it. This insecurity comes out in roundsmanship, compulsiveness, competitiveness, and often, outbursts towards those who question decisions or knowledge.

As the physician matures, he/she first learns to speak honestly about medicine to colleagues; then to speak honestly to patients (it is much harder to say to a patient "I don't know" than it is to say that to a colleague); third, to speak honestly to him/herself, knowing precisely what he/she knows and does not know; and finally, to accept without guilt the fact that he/she will always have gaps in his/her knowledge.

D. An Unlimited Regard for Human Life.

The physician down through the ages has been trained to put human life first in his/her list of priorities. This has always been important for a serious reason--so that the entire person of the physician could attend to the patient he/she contracted to help. This seems self evident, yet in our age there is a major onslaught against this quality. That we are having a world-wide debate about euthanasia is certainly a symptom of this. The abortion issue is certainly pertinent. But the most insidious assault against this quality comes from the increasing demand of society that the physician should not only care for the patient, but be the one responsible for controlling costs and allocating resources.

"A man cannot serve God and Mammon". Likewise, a physician cannot serve his/her patient and society. The two entities have different priorities. It is not that a physician should not be engaged in society and trying to influence the political system; but in the presence of the patient, nothing else should be distracting him/her from his best.

It is certainly true that we overutilize resources and waste health-care dollars. The physician has a responsibility to control this with respect to the individual patient. The adjuvant use of tamoxifen in the eighty year old woman with stage I breast cancer is a waste not because of societal priorities, but because of the fact that it is useless in this situation. The use of the

Continued on next page

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Religion of Medicine

Continued from previous page

intensive care unit to support the patient with a very high APACHE score is a waste because it will not change the outcome of the patient, not because it is expensive.

The good physician must cultivate a sense of seeing what future choices will arise from present choices. If there are none, there is no reason to make a present choice.

E. A Life-Long Hunger for Learning.

While it is true that medical knowledge has a distinct and palpable half-life, so that it is important to constantly update oneself, it is also noted that in practice, a physician who had not opened a book in 20 years could probably handle 75% of the complaints that the patient brings to him/her (depending on specialty of course). There have been examples of bright people who impersonated a physician successfully for many years.

While it goes without saying that a physician should update him/herself in medicine constantly, the hunger for learning should be global. A physician should be fascinated with medicine, but should have other fascinations. First, this is good for the physician; it exercises the critical faculties, and creates the necessary substrate for connecting areas of knowledge, a priority for understanding. Second, familiarity with other disciplines, from collecting wine to the study of physics, enhances the personality and improves the capacity for relationships. Third, within limits the constant use of the mind to acquire new learning extends the mental life of the physician.

F. The Ability to Pace Oneself.

A good physician is characterized by dedication to his/her patients, yes. But at the same time, the physician must be dedicated to his/her family, and most of all, to him/herself. The self, consisting of body and mind, is after all the vehicle which is used to serve the others. If the vehicle collapses, the patients will find other physicians and the family will somehow get along.

A good physician knows what must be done today and what can wait. He/she is in it for the long haul, and the work will still be there tomorrow, regardless of how much gets done today.

G. Respect for Other Physicians.

In general it isn't hard to respect most physicians; but there are always a few who seem ignorant, who are sloppy in their practice, who are substance abusers, who are sometimes, in fact, on the verge of mental illness.

The good physicians cultivates an attitude that there is something in all of these individuals which brought the person into the medical profession-there was a time when the person was willing to give up a great deal to achieve a goal which was linked to service. And indeed, there is still something worth rescuing in these fellow physicians. The quality of respect for one's fellow physicians is not a license to cover up, or to tolerate bad medicine. But if we maintain an openness with those of our profession who are troubled, there is the possibility of rescue. If we refuse to have anything to do with them, they may be unable to rescue themselves.

H. Humility

Physicians are generally not humble people. They have excellent minds, remarkable physical stamina, a great deal of self-confidence, and the ability to put off self-gratification to accomplish a goal. Most people are not so fortunate. Nevertheless, physicians will get old or sick; will fail more than they would like; and will meet others all through their careers who possess one or more of the above qualities in excess of themselves, thus potentially generating envy.

Humility is nothing more than self-knowledge. We need to consider where we are good and where we fail; what we know and don't know; what we can and can't do. And then, most importantly, we must accept ourselves as we are. Only after we achieve that state can we move ourselves in a direction which is positive for our whole being.

Different physicians would probably generate different lists of qualities. But it should be apparent by now how these relate to a religious stance. Religion (regardless of the type) is among other things, an attempt to change the human person away from selfishness and inwardness, to openness and connectedness to others. The practice of medicine in this sense has religious dimensions. The physician can use his/her life-long involvement in this most noble of professions to re-create his/her own self. Perhaps that is a reward greater than the gratitude of patients, the comfortable income, the absence of boredom, the admiration of society, and the satisfaction of healing. ■

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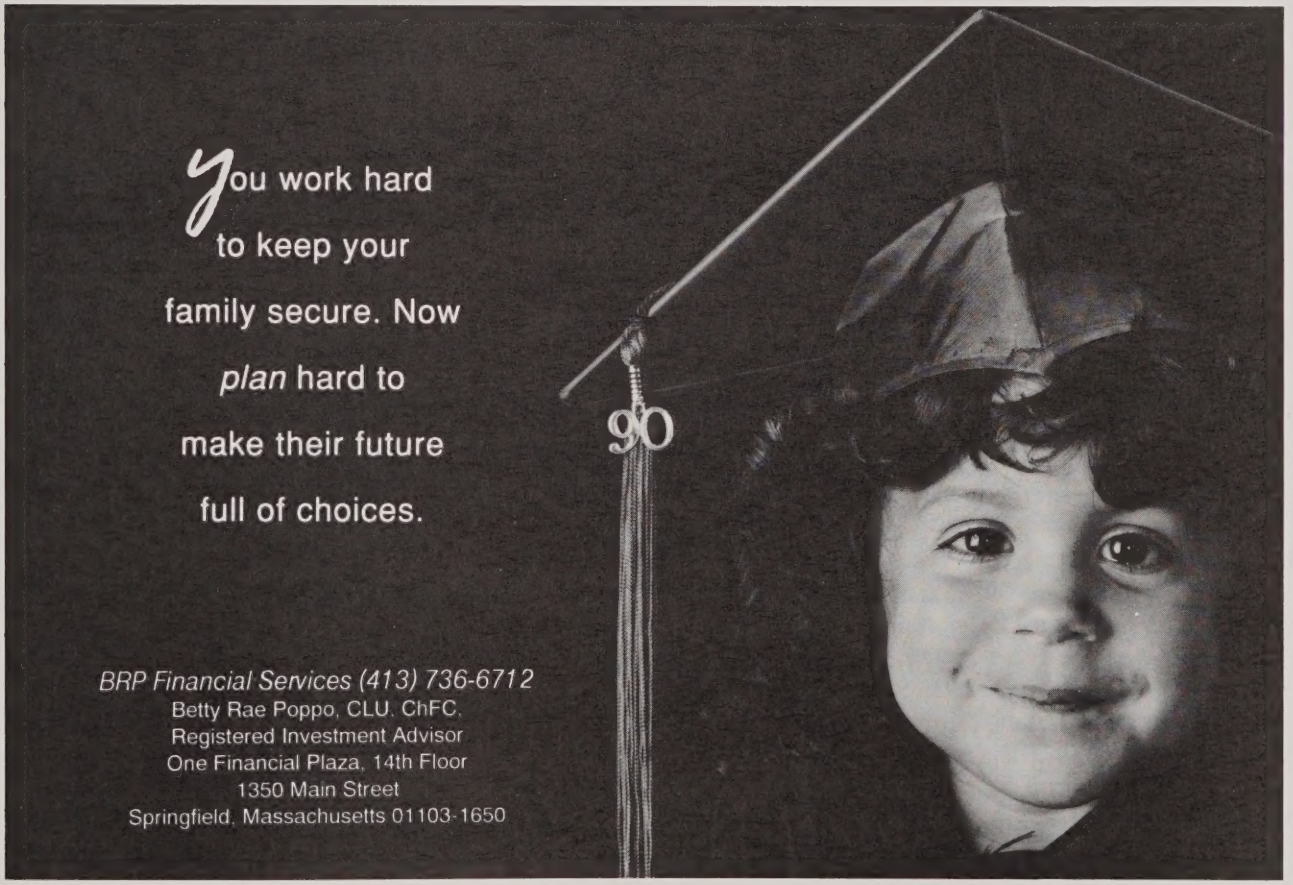

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Hampden Committee Activities

Our secretary brings us up to date on activities of the HDMS.

The Executive Committee met in September and October. The Student Health Video taped at Putnam High School in June is in the process of being edited by Dr. Alonzo Sheffield and Drs. Andrew and Heidi Moskovitz. Once the final tape is ready and it has been approved by the various organizations involved, it can be presented to classes countywide.

Dr. Horrigan reported on the Leadership Training Session and the Luncheon with Dr. Morse, both held this summer. The Leadership Training consisted of 4 sessions: media relations, community outreach, membership recruitment and a planning timetable for the District President. Those participating thought that the session was very informative and interesting, so much so that they requested a second session dealing with the topic of Media Training. This was held in September and attended by Dr. Horrigan and Dr. Francis Riley, our Public Health Committee Chairman. It has been suggested that an ad-hoc committee be set up to get members to join community service organizations and make the media more aware of Hampden District Medical Society.

The Luncheon with Dr. Leonard Morse at Storrowton Tavern completed a very hectic morning for Dr. Morse, President of the Massachusetts Medical Society. He met with Deloris Williams, Commissioner of the Springfield Public Health Department. From there, he visited Dr. Molly Noonan, Medical Director of Western Mass. Hospital in Westfield, His final visit of the morning was at Holyoke Hospital to discuss teenage pregnancy, drug abuse and care for the indigent. Dr. Horrigan was surprised to learn of the many people who contribute huge amounts of work in respect to these problems with no thought of renumeration or credit. He suggested that we develop a Public Service Award honoring a health care professional or lay person who has done outstanding public service work.

Dr. Horrigan also reported on a letter we received from Channel 40's news director in response to a letter he had written protesting the phone survey conducted after the death of basketball star Reggie Lewis. Channel 40 had asked the public to phone in their opinion as to whether the physician who treated Reggie Lewis should be held responsible for his death. Channel 40 agreed the survey was in poor taste and apologized.

Our District Meeting was held on September 20, 1993 at the Delaney House in Holyoke. Eighty-six members and guests attended to hear Dr. Gregory Connolly speak about smoking tobacco companies and tax dollars. Dr. Connolly is a dentist who works for the Mass. Department of Public Health Office for Non-Smoking. His presentation was excellent and was well received by those in attendance.

The Doctor-For-A-Day program was held on October 1, 1993. Twenty-six physicians from Hampden District Medical Society and their thirteen "interns" participated. A breakfast was held at Baystate Medical Center so that the "interns" could be introduced to the two physicians they would be working with, one in the morning and the other in the afternoon. A reception was held that evening at the Springfield Country Club to discuss the day's events. As always, the program was a huge success!

The Medico-Legal Committee held their Second Annual Forum on October 14, 1993 at Storrowton Tavern's Carriage House. Fifty physicians and lawyers attended the forum, titled "Medical-Legal Ramifications of the Health Care Proxy". Our speakers, George E. Karras, Jr., M.D. of Mercy Hospital's ICU/CCU and Attorney

Continued on next page

Hampden Committee Activities

Continued from previous page

Theodore Brown of Egan, Flanagan and Cohen, Reverend Gary DeLong of the First Church of Christ in Longmeadow, and Anne-Marie Ferraro, a pastoral giver for the Hospice of Pioneer Valley. Everyone involved with the program did an excellent job and plans are underway for Forum #10.

Dr. John Guntly, a veterinarian from Agawam Animal Hospital, spoke at the Public Health Committee meeting in September. Discussion centered on the rabies epidemic in Western Massachusetts. Dr. Guntly felt that physicians need to have more information and knowledge about rabies. Dr. Robert Hoffman, who specializes in infectious disease, has agreed to write an article in the Hippocrat with Dr. Guntly doing the introduction. ■

In Memoriam

Kalyan Chattopadhyay passed away September 25th. He was born and educated in Calcutta. After coming to this country, he trained at Montifiore Hospital in Anesthesia. He was chief of Anesthesiology at Holyoke Hospital. He leaves his wife, a son and a daughter. ■

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New Members Welcome

Barbara L. Ackerman, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 1, 1952
Premed: LaSalle University, PA 1982-1985
Medical: Temple University School of Medicine 1985-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-Present
Specialty: General Surgery
Resident:

Frank L. Dimase, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 17, 1966
Premed: Cornell University, New York 1984-1988
Medical: Albany Medical College 1993
Internship: Baystate Medical Center 1993-Present
Specialty: Emergency Medicine
Intern

Laxmikant Rathi, M.D.
67 Mulberry Street
Springfield, MA 01105

Born: November 11, 1928
Premed: Birla College Pilani
Medical: Nagpur University, India
Internship: University of Louisville Medical Center, KY 1957-1958
Residency: University of Louisville Medical Center 1958-1959
Fellowship: University of Louisville 1959-1960 (Pediatric Cardiology)
University of Virginia 1960-1962 (Surgical Cardiology)
Hospital for Sick Children, Canada 1962-1963 (Cardiology)
Specialty: Allergy/Immunology/Pediatric Allergy and Immunology

Philip J. Doherty, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 11, 1962
Premed: Wesleyan University, CT 1980-1984
Medical: Tulane University School of Medicine 1988-1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Internal Medicine/Pediatrics
Resident

Kevin P. Fitzgerald, M.D.
125 Liberty Street
Springfield, MA 01103

Born: June 14, 1963
Premed: LaSalle University, PA 1981-1985
Medical: Hahnemann University, PA 1985-1989
Internship: Baystate Medical Center 1989-1990
Residency: Baystate Medical Center 1990-1993
Specialty: Obstetrics/Gynecology

Donna L. O'Shea, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 4, 1958
Premed: University of New Hampshire 1976-1980
Medical: University of Rochester 1982-1986
Internship: University of Iowa Hospitals 1986-1987
Residency: University of Iowa Hospitals 1987-1990
Fellowship: Washington University, St. Louis, MO 1990-1992
Specialty: Obstetrics/Gynecology/Reproductive Endocrinology

Continued on next page

New Members Welcome

Continued from previous page

Joseph E. Moran, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 3, 1967
Premed: Fairfield University, CT 1985-1989
Medical: Robert Wood Johnson, New Jersey 1989-1993
Internship: Baystate Medical Center 1993-Present
Specialty: Internal Medicine
Intern

Lisa L. Norris, M.D.
477 Southwick Road
Westfield, MA 01085

Born: December 9, 1964
Premed: Ohio State University 1982-1986
Medical: Wright State University School of Medicine 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1993
Specialty: Pediatrics

Lisa M. Noyes, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 13, 1963
Premed: University of Connecticut 1981-1985
Medical: University of Connecticut Medical School 1990-1993
Internship: Baystate Medical Center 1993-Present
Specialty: Internal Medicine
Intern

Jeffrey P. Tannebaum, M.D.
444 Montgomery Street
Chicopee, MA 01020

Born: March 5, 1953
Premed: Boston University 1971-1977
Medical: Boston University School of Medicine 1973-1977
Internship: New York University School of Medicine/Manhattan VA 1977-1978
Residency: Maine Medical Center 1978-1980
Specialty: Family Practice

Joseph M. Bergen, D.O.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 1, 1961
Premed: U.S. Naval Academy, Maryland 1979-1983
Medical: University of New England College of Osteopathic Medicine 1988-1992
Internship: Ingham Medical Center, Michigan 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Emergency Medicine
Resident

Sabieli Kabeli, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 12, 1967
Premed: University College Hospital, London, England 1986-1991
Medical: University College Hospital, London, England 1986-1991
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Internal Medicine
Resident

Jeffrey Sussman
299 Carew Street
Springfield, MA 01104

Born: May 1, 1950
Premed: State University of New York at Buffalo 1968-1975
Medical: Autonomous University of Guadalajara 1976-1978
Temple University School of Medicine 1978-1980
Residency: Vanderbilt University 1980-1984
Fellowship: Yale University 1984-1986
Specialty: Pathology

Bill And Hilary Meet Santa

The following was dispatched by our White House reporter.

Bill and Hilary had put Chelsea to bed and were settling down to watch a re-run of Hee-Haw on Nick at Night. Bill had changed into his overalls and plaid shirt. His old dog Ruf lay at his feet, peacefully scratching fleas. He had a chaw of Red Man tobacco squinched up in his cheek, and a bottle of pretty good corn squeezin's sitting on the table. Hilary, of course, was off in the corner of the living room hoping that Bill would keep the volume down and not spit too much, so that she could concentrate on the problems facing the country. God knows Bill wasn't, and didn't care either.

It wasn't too bad an evening. Bill dozed off; the dog went outside, and Hilary was able to turn Buck Owens and Ray Clark down to a soft murmur.

Suddenly there was a rush of wind and the shutters blew open. In a few moments, Santa materialized in the middle of the room.

Bill woke with a start, spit a wad of tobacco juice into the Abraham Lincoln Spitoon, and took another swig of 'shine. Hilary was on her feet in an instant, and thinking to rush over to the phone and press the button which called for security, but paralyzed by indecision—if this intruder shot Bill enough to take him out of action and not enough to eliminate him entirely, she could certainly get a lot done; but the risk was that Al Gore would end up with all the power, and that would be even worse than having a Republican in office, because Al was clearly funny about trees and squirrels, to the point of ignoring everything else.

"Take it easy," said the Jolly Elf, seemingly reading her mind. "I just stopped by to see if there was anything you wanted for Christmas." He puffed merrily on his pipe and blew a few smoke rings in the air.

"First, put the pipe out," said the First Lady. "The White House is a Smoke-free government facility, and I suspect that you haven't paid tax on that tobacco if you bought it in some other country."

"Second," she went on, "get off the good rug. You're dripping snow all over. Third, don't you ever bathe? Fourth, why aren't you taking turns delivering presents with Mrs. Santa Claus, you unreconstructed male chauvinist pig? Fifth, you may be an immortal spirit, but we Democrats don't believe in any such thing, so far as I'm concerned, you don't exist, Sixth..."

"Hold on, Hilary!" interrupted Bill, receiving for his pains a glare that would freeze a bonfire. "I think Santa wants to give us something." Bill, like most Democrats, had a touching faith that one could get something for nothing even though even baboons knew better.

"Santa," continued Bill, "I'd like a new hunting dog, a case of Bill Abner's finest 'shine, One of them Pawpaw pies, a good ol' pick-up truck, and an autographed pitchur of Reba MacIntyre."

"I think you misunderstand me," said Saint Nick. "I was hoping to find out what the country needs."

"Oh", said Bill, who abruptly lost interest in the conversation, sat back down in his chair, turned up the volume of the TeeVee, and was soon dozing again, tobacco juice drooling out of the corner of his mouth.

"Lets say you're telling the truth," said Hilary after everything was back to normal. "Not that I believe a word of it! You're telling me that you can provide what the country needs?"

"Sure," said Santa. "I can do anything I want."

"Okay," said the First Lady. "I guess it can't hurt to ask."

"That's the spirit," said the Old Elf.

"I want a fair and equitable health care system!" said Hilary.

"That's simple," said Santa. "Decide how much you want to spend, then add that much to the nation's tax burden. Close down all the current systems of health insurance. Set up a commission to decide what conditions will be covered and what won't. Look at what's happening every year and revise the program according to what is needed."

"We can't raise taxes," said Hilary, "at least not in so obvious a way. Besides, we get political contributions from the insurance industry. And while I would dearly love to put those arrogant physicians in their place, at the

Continued on next page

Bill And Hilary Meet Santa

Continued from previous page

present time they are still too powerful to take on all at once. And besides, if we created a list of what is covered and what isn't, that would be rationing, and we'd be living back in Arkansas before we knew it."

"Okay," said Santa. "Scratch that. Anything else?"

"I know!" said Hilary. "What about getting rid of the national debt? I know that would be a good thing!"

"Easy," said Santa. "Just raise taxes to cover the debt, or quit spending so much."

"I don't think the country could go along with either," said the First Lady. "And that would guarantee that we'd be living in Arkansas before we knew it."

She thought hard for several minutes.

"I've got it!" she said. "this country could really use a lot more jobs! Then maybe we could get people off welfare, and raise the average income, and increase the tax base—why, it's perfect!"

"Easy," said Santa. "First you need to eliminate trade barriers. Second, you need to encourage businesses to create more jobs by cutting taxes. Third, you need to eliminate about ¾ of the regulations they have to follow to stay in business. Fourth..."

"Stop!" said Hilary. "Those are all *bad things* to a Democrat. And I don't want to spend my old age sitting around some unpainted one room shack in Arkansas while Bill spits and scratches himself. I guess you can't help us at all."

"Surely there must be something", said Santa.

"Oh, get Bill that pickup truck he's always talking about", said Hilary. "Maybe that will get him out of my hair long enough to get a few things done around here. ■

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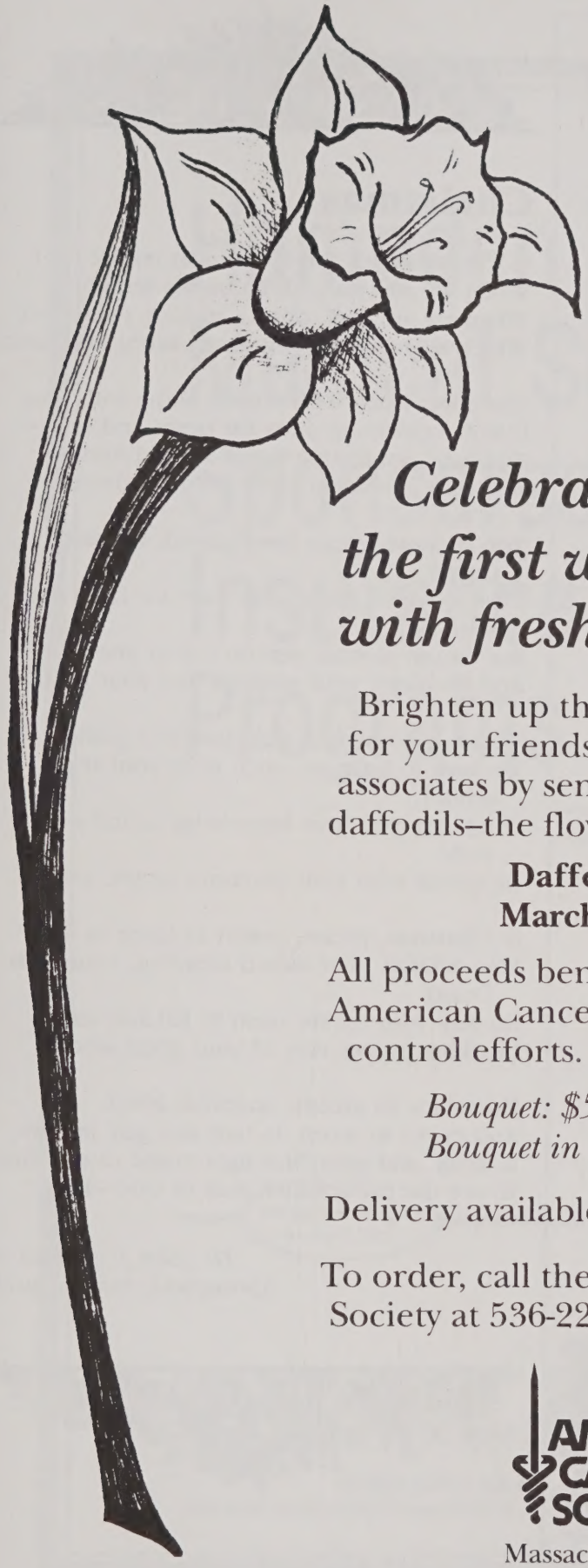

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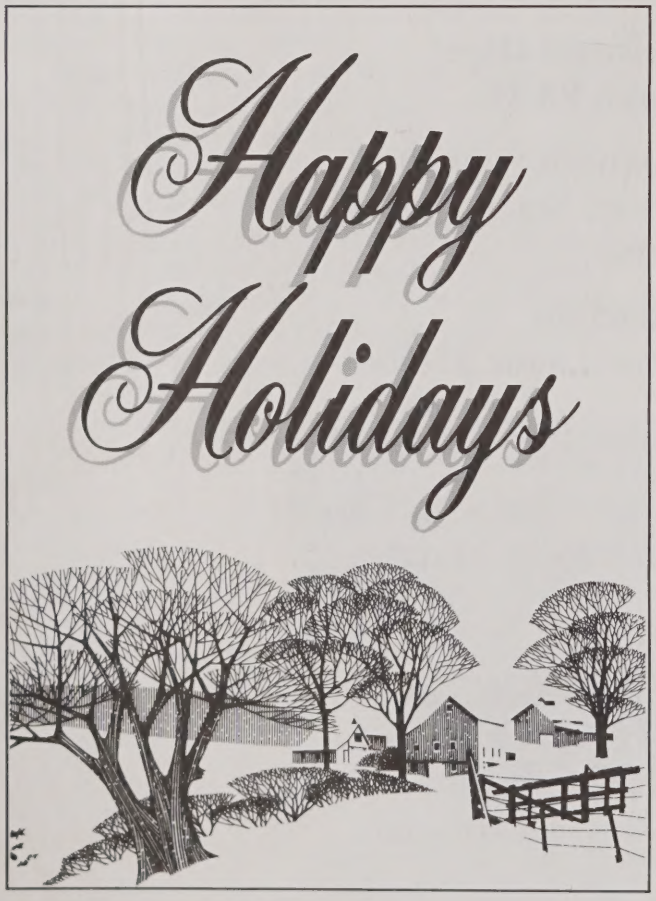

Christmas

O Christmas, lo! it is arduous to rejoice
When we still walk on an unsafe terrain;
When we are deaf, obtuse, to hear your voice
Which tells us to redeem from wrong and strain.

You come again with intents blithe and clear,
Intents containing pleas for peace and love—
Emphatic points that hover far and near
Sent here on planet earth from up above.

Two thousand years have passed, O Feast
divine
That you have shown the ways for heart and
soul;
But we, all mortals, remain out of line
And do forget your message and your goal.

We are like children that deserve a guide:
We have to learn so much from your true
school.
O teacher, you have knowledge sound and
wide
To spread with your perennial mystic tool.

O Christmas, please, persist to teach us all
Your WORD, your sacred meaning, your great
Creed.
Do stay with us; we seem to fail and stall
In taking proper care of your good seed.

Humanity, so greedy, doubtful, blind
And prone to scorn, to hate and stay in dark,
Is weak, and your firm light-house cannot find
To see the paths which lead to God—life's
spark. ■

Dr. John J. Alifano, Sr.
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For more information about any of our organizations, please call our main office at (413) 737-3981.

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